		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039339

Facility Name: Jerseyville Nursing and Rehabilitation Center

Address: 1001 South State Street (Number) Jerseyville (City) 62052 (Zip Code)

County: Jersey

Telephone Number: (618) 498-6496 **Fax #** (618) 498-7435

IDPA ID Number: 37-1323741

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		10,691	2,558	13,249	8
9	SNF/PED					9
10	ICF	18,986			18,986	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,986	10,691	2,558	32,235	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.44%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 2,558

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	139,632	16,782	4,488	160,902		160,902		160,902			1
2	Food Purchase		146,961		146,961		146,961	(1,987)	144,974			2
3	Housekeeping	73,974	13,267		87,241		87,241		87,241			3
4	Laundry	69,093	15,956		85,049		85,049	(62)	84,987			4
5	Heat and Other Utilities			95,972	95,972		95,972	781	96,753			5
6	Maintenance	48,794	5,470	32,585	86,849		86,849	(751)	86,098			6
7	Other (specify):* Waste Removal			6,178	6,178		6,178		6,178			7
8	**TOTAL General Services**	331,493	198,436	139,223	669,152		669,152	(2,019)	667,133			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	914,906	75,041	2,568	992,515	(2,497)	990,018	(84)	989,934			10
10a	Therapy	33,517	1,719	187,807	223,043		223,043	(21,155)	201,888			10a
11	Activities	31,359	2,193	1,290	34,842	826	35,668		35,668			11
12	Social Services	21,715		1,358	23,073		23,073		23,073			12
13	Nurse Aide Training					2,950	2,950		2,950			13
14	Program Transportation		1,745		1,745		1,745		1,745			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,001,497	80,698	202,623	1,284,818	1,279	1,286,097	(21,239)	1,264,858			16
	C. General Administration											
17	Administrative	59,748	13,036	159,579	232,363	(9,088)	223,275	(62,234)	161,041			17
18	Directors Fees											18
19	Professional Services			69,420	69,420	(1,500)	67,920	27,786	95,706			19
20	Dues, Fees, Subscriptions & Promotions			37,698	37,698	(709)	36,989	(15,361)	21,628			20
21	Clerical & General Office Expenses	68,361	12,729	26,109	107,199		107,199	24,824	132,023			21
22	Employee Benefits & Payroll Taxes			199,973	199,973	50	200,023	12,560	212,583			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,404	7,404	(32)	7,372	(1,001)	6,371			24
25	Other Admin. Staff Transportation							3,164	3,164			25
26	Insurance-Prop.Liab.Malpractice			47,522	47,522	10,000	57,522	3,009	60,531			26
27	Other (specify):*											27
28	**TOTAL General Administration**	128,109	25,765	547,705	701,579	(1,279)	700,300	(7,253)	693,047			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,461,099	304,899	889,551	2,655,549		2,655,549	(30,511)	2,625,038			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center #0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			148,169	148,169		148,169	8,195	156,364			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			276,186	276,186		276,186	(15,545)	260,641			32
33	Real Estate Taxes			23,113	23,113		23,113	1,001	24,114			33
34	Rent-Facility & Grounds							5,231	5,231			34
35	Rent-Equipment & Vehicles			4,857	4,857		4,857		4,857			35
36	Other (specify):* **Mortgage Ins.**			23,039	23,039		23,039		23,039			36
37	**TOTAL Ownership**			475,364	475,364		475,364	(1,118)	474,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,442	9,368	95,810		95,810		95,810			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		86,442	64,665	151,107		151,107		151,107			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,461,099	391,341	1,429,580	3,282,020		3,282,020	(31,629)	3,250,391			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,987)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,330)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,003)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(289)	20		18
19	Entertainment	(2,092)	24		19
20	Contributions	(709)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,163)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,854)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,427)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,202)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,202)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (31,629)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Jerseyville Nursing and Rehabilitation Center

ID# 0039339

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income	$ (62)	4	1
2	Offset Miscellaneous Income	(1,454)	6	2
3	Offset Miscellaneous Income	(290)	22	3
4	Offset Miscellaneous Income	(84)	10	4
5	Offset Miscellaneous Income	(240)	20	5
6	PAC & Lobbying Dues	(1,924)	20	6
7	2001 IDPH License Pd in 2000	200	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,854)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,987)	0	0	0	0	0	0	0	0	0	0	(1,987)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(62)	0	0	0	0	0	0	0	0	0	0	(62)	4
5	Heat and Other Utilities	0	781	0	0	0	0	0	0	0	0	0	781	5
6	Maintenance	(1,454)	703	0	0	0	0	0	0	0	0	0	(751)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,503)	1,484	0	0	0	0	0	0	0	0	0	(2,019)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(84)	0	0	0	0	0	0	0	0	0	0	(84)	10
10a	Therapy	0	0	(21,155)	0	0	0	0	0	0	0	0	(21,155)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(84)	0	(21,155)	0	0	0	0	0	0	0	0	(21,239)	16
	C. General Administration													
17	Administrative	(1,003)	98,348	(159,579)	0	0	0	0	0	0	0	0	(62,234)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(785)	28,571	0	0	0	0	0	0	0	0	27,786	19
20	Fees, Subscriptions & Promotions	(16,125)	764	0	0	0	0	0	0	0	0	0	(15,361)	20
21	Clerical & General Office Expenses	0	24,824	0	0	0	0	0	0	0	0	0	24,824	21
22	Employee Benefits & Payroll Taxes	(290)	12,850	0	0	0	0	0	0	0	0	0	12,560	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,092)	1,091	0	0	0	0	0	0	0	0	0	(1,001)	24
25	Other Admin. Staff Transportation	0	3,164	0	0	0	0	0	0	0	0	0	3,164	25
26	Insurance-Prop.Liab.Malpractice	0	3,009	0	0	0	0	0	0	0	0	0	3,009	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(19,510)	143,265	(131,008)	0	0	0	0	0	0	0	0	(7,253)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,097)	144,749	(152,163)	0	0	0	0	0	0	0	0	(30,511)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	8,195	0	0	0	0	0	0	0	0	0	8,195	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,330)	227	(8,442)	0	0	0	0	0	0	0	0	(15,545)	32
33	Real Estate Taxes	0	1,001	0	0	0	0	0	0	0	0	0	1,001	33
34	Rent-Facility & Grounds	0	0	5,231	0	0	0	0	0	0	0	0	5,231	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,330)	9,423	(3,211)	0	0	0	0	0	0	0	0	(1,118)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,427)	154,172	(155,374)	0	0	0	0	0	0	0	0	(31,629)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00%	Montgomery Health Care Center	Hillsboro, IL	Wellington Mgmt Co	Chesterfield, MO	Management Co.
David L. Kamler	10.00%	Westwood Hills Healthcare Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co.
J. Terry Dooling	10.00%			C.J. Schlosser & Co.	Alton, IL	Public Accountants
R.J. Tolliver	10.00%			NW Rehab, L.L.C.	Alton, IL	Therapy Co.
Jack A. Yaeger	10.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 781	$ 781	1
2	V	6	See Schedule VIII		Wellington Management Co.	60.00%	703	703	2
3	V	17	See Schedule VIII		Wellington Management Co.	60.00%	98,348	98,348	3
4	V	19	See Schedule VIII		Wellington Management Co.	60.00%	(785)	(785)	4
5	V	20	See Schedule VIII		Wellington Management Co.	60.00%	764	764	5
6	V	21	See Schedule VIII		Wellington Management Co.	60.00%	24,824	24,824	6
7	V	22	See Schedule VIII		Wellington Management Co.	60.00%	12,850	12,850	7
8	V	24	See Schedule VIII		Wellington Management Co.	60.00%	1,091	1,091	8
9	V	25	See Schedule VIII		Wellington Management Co.	60.00%	3,164	3,164	9
10	V	26	See Schedule VIII		Wellington Management Co.	60.00%	3,009	3,009	10
11	V	30	See Schedule VIII		Wellington Management Co.	60.00%	8,195	8,195	11
12	V	32	See Schedule VIII		Wellington Management Co.	60.00%	227	227	12
13	V	33	See Schedule VIII		Wellington Management Co.	60.00%	1,001	1,001	13
14	Total			$			$ 154,172	$ * 154,172	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 5,231	$ 5,231	15
16	V	17	Management Fees	114,897	Wellington Management Co.	60.00%		(114,897)	16
17	V	17	Management Fees	44,682	Health Care Financial, L.L.C.	40.00%		(44,682)	17
18	V	19	Professional Services	34,913	C.J. Schlosser & Company, L.L.C.	40.00%		(34,913)	18
19	V	19	Professional Services		C.J. Schlosser & Company, L.L.C.	40.00%	63,484	63,484	19
20	V	10a	Therapy Services	187,807	NW Rehab, L.L.C.	100.00%	166,652	(21,155)	20
21	V	32	Interest	8,442	John H. Rothert	60.00%		(8,442)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 390,741			$ 235,367	$ * (155,374)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	John H. Rothert	President	Administrative	60.00%	179,726	12	30.00	Salary	$ 77,296	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,296		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Welllington Management Company
Street Address: 750 Spririt 40 Court
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (314) 537-8447
Fax Number: (314) 537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	10,037,907	4	$ 2,596	$	3,018,767	$ 781	1
2	6	Maintenance	Accumulated Costs	10,037,907	4	2,337		3,018,767	703	2
3	17	Administrative	Accumulated Costs	10,037,907	4	327,022	327,022	3,018,767	98,348	3
4	19	Professional Services	Accumulated Costs	10,037,907	4	(2,609)		3,018,767	(785)	4
5	20	Fees, Subscriptions and Promos	Accumulated Costs	10,037,907	4	2,540		3,018,767	764	5
6	21	Clerical & General Office Exp.	Accumulated Costs	10,037,907	4	82,544	48,490	3,018,767	24,824	6
7	22	Employee Benefits & PR Taxes	Accumulated Costs	10,037,907	4	42,730		3,018,767	12,850	7
8	24	Travel and Seminar	Accumulated Costs	10,037,907	4	3,629		3,018,767	1,091	8
9	25	Other Admin. Staff Transport	Accumulated Costs	10,037,907	4	10,521		3,018,767	3,164	9
10	26	Insurance - Prop.,Liab.,Malprac.	Accumulated Costs	10,037,907	4	10,004		3,018,767	3,009	10
11	30	Depreciation	Accumulated Costs	10,037,907	4	27,251		3,018,767	8,195	11
12	32	Interest	Accumulated Costs	10,037,907	4	756		3,018,767	227	12
13	33	Real Estate Taxes	Accumulated Costs	10,037,907	4	3,329		3,018,767	1,001	13
14	34	Rent - Facility & Grounds	Accumulated Costs	10,037,907	4	17,395		3,018,767	5,231	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 530,045	$ 375,512		$ 159,403	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Cente # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Mortgage Loan	$26,697.36	04/17/2000	$ 3,720,700	$ 3,686,933	05/01/2035	8.100%	$ 262,405	1
2												2
3	Chrysler Financial		X	Vehicle Loan	$658.80	09/30/2000	23,391	13,721	09/30/2003	0.900%	161	3
4									Loan Cost Amortization		5,178	4
5												5
	Working Capital											
6												6
7									Home Office Allocation		227	7
8												8
9	TOTAL Facility Related				$27,356.16		$ 3,744,091	$ 3,700,654			$ 267,971	9
	B. Non-Facility Related*											
10									Interest Income		(7,330)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,330)	14
15	TOTALS (line 9+line14)						$ 3,744,091	$ 3,700,654			$ 260,641	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	24,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	23,113	2
3. Under or (over) accrual (line 2 minus line 1).	$	(887)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	24,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	23,113	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	24,081	8
1997	23,276	9
1998	23,681	10
1999	23,468	11
2000	23,113	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Line 2: 2000 Taxes Paid

Line 4: Accrual is based on 2000 taxes paid plus approximately 4%

Line 7: $23,113 + $1,001 (Home Office R.E. Tax Allocation) = Total R.E. Taxes of $24,114, Schedule V, Col.8.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jerseyville Nursing and Rehabilitation Center COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039339

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-875-004-00	Outlots 59, 62, 63 & 64 S Pt Outlot 62	$ 22,596.90	$ 22,596.90
2.	04-208-017-00	S28 T8 R11 Unplatted Parcels	$	$
3.		S & W PT SE 1/4 NE 1/4 Less E PT	$ 516.28	$ 516.28
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,113.18	$ 23,113.18

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,948 B. General Construction Type: Exterior Brick & Siding Frame Steel and Brick Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	158,994	1994	$ 71,664	1
2					2
3	TOTALS	158,994		$ 71,664	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 1,180,668	$ 47,227	25	$ 47,227	$	$ 366,007	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot			1994	26,304	2,469	5-10	2,469		20,169	9
10	Exterior Remodeling			1994	10,000	667	15	667		5,056	10
11	Flooring			1994	29,698	2,970	10	2,970		21,952	11
12	Electrical			1994	11,690	584	20	584		4,234	12
13	Air Conditioning			1994	25,830	2,583	10	2,583		18,942	13
14	Interior Remodeling			1994	40,265	1,359	5-20	1,359		29,535	14
15	Shed			1994	3,267	327	10	327		2,505	15
16	Nurses' Station			1994	6,055	303	20	303		2,296	16
17	Home Office Wallpapering/Flooring			1994	4,755		5			4,755	17
18	Painting			1995	7,392		5			7,392	18
19	Electrical			1995	3,382	338	10	338		2,311	19
20	Call Lights			1995	1,564	104	15	104		652	20
21	Storage Building			1996	3,500	350	10	350		1,750	21
22	2 Boilers			1996	7,400	370	20	370		2,189	22
23	Roof Repairs & Drains Installed			1996	3,619	362	10	362		2,081	23
24	Ceiling Tile & End Caps			1996	3,506	292	12	292		1,510	24
25	Storage Building			1997	3,356	336	10	336		1,650	25
26	Alarm System			1997	1,750	175	10	175		860	26
27	Wallcovering			1997	6,355	953	5-10	953		4,269	27
28	Ceiling Tile			1997	1,485	124	12	124		557	28
29	3 Windows & Sills & 1 Door Replaced			1997	4,108	274	15	274		1,187	29
30	Baseboards Remodeled			1997	1,166	116	10	116		506	30
31	Air Conditioner Units			1997	2,185	219	10	219		977	31
32	Concrete Patio & Sidewalk			1997	1,842	123	15	123		532	32
33	Rock			1997	502	100	5	100		485	33
34	Landscaping			1997	1,075	108	10	108		502	34
35	Roofing			1998	2,592	259	10	259		1,015	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Shower Room Remodel	1998	$ 1,437	$ 144	10	$ 144	$	$ 563	37
38	Baseboard Remodeling	1998	1,919	192	10	192		695	38
39	Air Conditioning Units & Ducts	1998	13,420	1,280	10-20	1,280		4,458	39
40	Wallcoverings	1998	1,495	149	10	149		461	40
41	4 Air Conditioning Units	1999	2,840	284	10	284		686	41
42	Roofing	1999	35,386	3,539	10	3,539		9,731	42
43	Home Office Wallpapering	1999	800		5	160	160	453	43
44	3 Air Conditioning Units	2000	2,118	212	10	212		300	44
45	Wallcoverings	2000	2,231	446	5	446		632	45
46	Chair Railings	2000	6,267	418	15	418		449	46
47	Cove Base	2000	1,797	180	10	180		180	47
48	Constr. of 400 Wing-Design, Architecture & Engineering	2001	67,723	1,354	25	1,354		1,354	48
49	Constr. Of 400 Wing-Contractor Costs	2001	943,708	18,874	25	18,874		18,874	49
50	Constr. Of 400 Wing-Drawings, Surety Bond & Misc.	2001	11,223	224	25	224		224	50
51	Constr. Of 400 Wing-Interest & Mortgage Ins. Premiums	2001	89,316	1,786	25	1,786		1,786	51
52	400 Wing Nurse Call System	2001	10,104	337	15	337		337	52
53	400 Wing Cable TV System Cabling	2001	1,962	98	10	98		98	53
54	400 Wing Fire Alarm System	2001	14,696	490	15	490		490	54
55	400 Wing Telecommunication System	2001	4,025	201	10	201		201	55
56	400 Wing Door Monitor System	2001	2,640	132	10	132		132	56
57	400 Wing TV Wall Mounts	2001	6,030	302	10	302		302	57
58	400 Wing Signage	2001	1,161	116	5	116		116	58
59	400 Wing Hand Rails & Wall Guards	2001	2,319	77	15	77		77	59
60	400 Wing Chair Rails, Wallpaper & Border	2001	4,208	421	5	421		421	60
61	400 Wing Door Guards	2001	607	61	5	61		61	61
62	400 Wing Cubicle Tracks & Curtains & Window Treatments	2001	15,188	981	5-20	981		981	62
63	Landscaping, Shrubs & Trees	2001	11,744	881	10	881		881	63
64	Fencing	2001	4,200	350	8	350		350	64
65	Wallpaper & Border-Existing Facility	2001	55,671	10,432	5	10,432		10,432	65
66	Storage Building	2001	3,268	272	10	272		272	66
67	Carpet-Administrative Offices	2001	2,687	448	5	448		448	67
68	Nurse Call System Services-Existing Facility	2001	3,700	144	15	144		144	68
69	Alarm System Services-Existing Facility	2001	3,903	260	15	260		260	69
70	TOTAL (lines 4 thru 69)		$ 2,725,104	$ 108,177		$ 108,337	$ 160	$ 562,725	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,725,104	$ 108,177		$ 108,337	$ 160	$ 562,725	1
2	Replacement Signage-Existing Facility	2001	3,656	609	5	609		609	2
3	Door Guards-Existing Facility	2001	1,979	231	5	231		231	3
4	Vinyl Flooring & Cove Base-400 Wing	2001	11,615	581	10	581		581	4
5	25 Overbed Lights	2001	1,625	68	10	68		68	5
6	Painting Door Frames	2001	8,932	1,340	5	1,340		1,340	6
7	2P 50 Amp Disconnect	2001	955	20	20	20		20	7
8	Mini Blinds, Valances & Rods	2001	14,744	491	5	491		491	8
9	Asphalt Paving of Parking Lot	2001	14,193	946	10	946		946	9
10	A/C Units	2001	3,424	187	10	187		187	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,786,227	$ 112,650		$ 112,810	$ 160	$ 567,198	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 182,428	$ 16,331	$ 18,532	$ 2,201	5-20	$ 61,525	71
72	Current Year Purchases	76,555	3,411	3,434	23	5-20	3,434	72
73	Fully Depreciated Assets	260,171	9,548	9,548		5-7	260,171	73
74								74
75	TOTALS	$ 519,154	$ 29,290	$ 31,514	$ 2,224		$ 325,130	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2000 Dodge Grand Caravan	2000	$ 24,916	$ 6,229	$ 6,229	$	4	$ 7,786	76
77	Home Office Admin	1999 Taurus	Acq.'99,Sold'00			935	935	4		77
78	Home Office Admin	2000 Taurus	2000	7,163		1,791	1,791	4	2,388	78
79	See Attached Schedule			12,342		3,085	3,085	4	5,083	79
80	TOTALS			$ 44,421	$ 6,229	$ 12,040	$ 5,811		$ 15,257	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,421,466	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,169	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 156,364	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,195	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 907,585	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	None	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [N/A] YES [N/A] NO

16. Rental Amount for movable equipment: $ 4,857 Description: Copier $4,408, Postage Machine $449
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 75

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 100

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	1,400	1,400		2,800
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			150		150
9	TOTALS		$ 1,400	$ 1,550	$	$ 2,950
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,950			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	3152 hrs	$ 78,760		$	$ 1,240	3,152	$ 80,000	1
2	Licensed Speech and Language Development Therapist	10a,8	626 hrs	19,436			15	626	19,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	2704 hrs	68,456			464	2,704	68,920	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				56,880		56,880	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	IV Therapy Other (specify): Lab Fees	39,2 39,3				9,368	29,562		29,562 9,368	13
14	TOTAL			$ 166,652		$ 9,368	$ 88,161	6,482	$ 264,181	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 87,256	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 31,179)	462,148		3
4	Supply Inventory (priced at cost)	12,067		4
5	Short-Term Investments			5
6	Prepaid Insurance	55,226		6
7	Other Prepaid Expenses	3,709		7
8	Accounts Receivable (owners or related parties)	79,116		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 699,522	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,250		12
13	Land	131,523		13
14	Buildings, at Historical Cost	2,720,814		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	524,525		16
17	Accumulated Depreciation (book methods)	(882,422)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	52,953		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	172,365		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,725,008	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,424,530	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 337,820	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,817		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,770		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due from Stockholder	85,000		36
37	Accrued Expenses	766		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 556,173	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	37,120		39
40	Mortgage Payable	3,686,933		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,724,053	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,280,226	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (855,696)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,424,530	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (849,154)	1
2	Restatements (describe):		2
3	**Prior Year Bad Debts Adjustment**	(12,956)	3
4	**Prior Year Construction Escrow Interest Adjustment**	(10,015)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (872,125)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	16,429	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 16,429	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (855,696)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,199,374	1
2	Discounts and Allowances for all Levels	(330,218)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,869,156	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	7,212	5
6	Therapy	289,999	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 297,211	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	767	13
14	Non-Patient Meals	1,987	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	91,895	19
20	Radiology and X-Ray	4,055	20
21	Other Medical Services	18,375	21
22	Laundry	1,285	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,364	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,043	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,043	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	375	28
28a	Miscellaneous Income	5,300	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,675	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,298,449	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	669,152	31
32	Health Care	1,284,818	32
33	General Administration	701,579	33
	B. Capital Expense		
34	Ownership	475,364	34
	C. Ancillary Expense		
35	Special Cost Centers	95,810	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,282,020	40
41	**Income before Income Taxes (line 30 minus line 40)****	16,429	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 16,429	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet filed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,839	2,316	$ 45,786	$ 19.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,327	7,584	120,184	15.85	3
4	Licensed Practical Nurses	18,878	20,423	258,726	12.67	4
5	Nurse Aides & Orderlies	51,801	56,319	469,212	8.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,397	3,719	33,517	9.01	8
9	Activity Director					9
10	Activity Assistants	3,878	4,354	31,359	7.20	10
11	Social Service Workers	1,908	2,111	21,715	10.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,031	21,187	139,632	6.59	15
16	Dishwashers					16
17	Maintenance Workers	4,587	4,848	48,794	10.06	17
18	Housekeepers	10,253	11,044	73,974	6.70	18
19	Laundry	9,988	10,574	69,093	6.53	19
20	Administrator	2,067	2,139	59,748	27.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,551	6,077	68,361	11.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,894	2,128	20,998	9.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,399	154,823	$ 1,461,099 *	$ 9.44	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	148	$ 4,488	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	24	1,068	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,500	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,290	11,3	44
45	Social Service Consultant	25	1,358	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	220	$ 19,304		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terrie Skaggs	Administrator	0.00	$ 59,748
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,748

B. Administrative - Other

Description	Amount
Wellington Management Company - Management Fees	$ 114,897
Health Care Financial, L.L.C. - Management Fees	44,682
TOTAL (agree to Schedule V, line 17, col. 3)	$ 159,579
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Fees	$ 34,913
Ted Frapolli	Legal Fees	12,510
Duane, Morris & Heckscher, LLP	Legal Fees	4,651
Sandberg, Phoenix & von Gontard	Legal Fees	180
Newman, Goldfarb	Legal Fees	270
Scott W. Schultz	Legal Fees	2,480
McMahon, Berger	Legal Fees	51
Hughes & Associates	Audit Fees	4,365
Insurance Deductible		10,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 69,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,650
Unemployment Compensation Insurance	13,178
FICA Taxes	106,403
Employee Health Insurance	19,467
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Disability Insurance	558
Employee Dental Insurance	645
Staff Relations	11,761
Employee Physicals	71
Home Office Employee Benefits	12,850
TOTAL (agree to Schedule V, line 22, col.8)	$ 212,583

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	13,731
Health Care Worker Background Check	
(Indicate # of checks performed 25)	304
Licenses & Fees	490
Dues & Subscriptions	5,162
Service Charges	977
Home Office Dues, Fees, Subscriptions	764
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,488
Seminar Expense	792
Home Office Travel & Seminar	1,091
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,371

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jerseyville Nursing and Rehabilitation Center # 0039339 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $3,962**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,987**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **17%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Hughes & Associates, CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet complete.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

JERSEYVILLE NURSING AND REHABILITATION CENTER
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/01

DESCRIPTION	LINE #	INCREASE (DECREASE)
ADMINISTRATIVE	17	(9,463)
NURSING & MEDICAL RECORDS	10	303
PROFESSIONAL SERVICES	19	8,500
FEES, SUBSCRIPTIONS & PROMOTIONS	20	12
TRAVEL & SEMINAR	24	158
ACTIVITIES	11	440
EMPLOYEE BENEFITS	22	50
To reclass various expenses to proper lines		
ADMINISTRATIVE	17	375
ACTIVITIES	11	386
FEES, SUBSCRIPTIONS & PROMOTIONS	20	(761)
To reclass supplies included in promotional advertising to proper line		
FEES, SUBSCRIPTIONS & PROMOTIONS	20	190
TRAVEL & SEMINAR	24	(190)
To reclass dues to proper line		
NURSE AIDE TRAINING	13	2,950
NURSING & MEDICAL RECORDS	10	(2,800)
FEES, SUBSCRIPTIONS & PROMOTIONS	20	(150)
To reclass CNA test fees & trainer wages		
INSURANCE -PROP.LIAB.MALPRACTICE	26	10,000
PROFESSIONAL SERVICES	19	(10,000)
To reclass insurance deductible		

Jerseyville Nursing & Rehabilitation Center, Inc.
Attachment to Sch. XI, Part D
December 31, 2001

Detail of Line 79: Home Office Admin Vehicles

Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
1997 Jaguar	2000	11,765		2,941	2,941	4	4,902
1992 Minivan	2000	577		144	144	4	181
		12,342	0	3,085	3,085		5,083

JERSEYVILLE NURSING AND REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO MEDICAID COST REPORT
12/31/01

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/ TRAVEL/MEALS
Monica Watson	RN	4/23-27, 2001	Springfield, IL	CNA Instructor Course for RN's	Lincoln Land Community College	140	276
Ann Ridings	Dir. of Operations	5/25/2001	St. Louis, MO.	Supporting Mental Wellness in Older Adults	Missouri League for Nursing	105	
Terrie Skaggs	Administrator	5/25/2001	St. Louis, MO.	Supporting Mental Wellness in Older Adults	Missouri League for Nursing	105	
Monica Watson	RN	10/11/2001	Springfield, IL	MDS-By the Book	Illinois Health Care Association	85	
Lisa Sidwell	LPN	10/11/2001	Springfield, IL	MDS-By the Book	Illinois Health Care Association	65	
Various	Various	4/01	Jerseyville, IL	CPR Course	Red Cross	60	
Cindy Bloodworth	Activities	11/14/2001	Mt. Vernon, IL	Beyond the Basics	Outcome Services	68	
Terrie Skaggs	Administrator	10/10/2001	Bethany, MO.	Site Visit/Seminar-Person Centered Program	Mo. Assoc. of Homes for Aging	97	
Robin White	DON	8/01	Lake Ozark, MO	DON Convention	Missouri Health Care Assoc.	67	221
					Total Seminars	792	497
				Total Seminar Lodging/Travel/Meals		497	
				Other Travel Expense <$250 each		3,622	
				Home Office Travel & Seminar		1,091	
				Other Misc. Travel & Seminar		369	
					Total Travel and Seminar, Line 24	6,371	